Usefulness of collaborating with clergy

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When I attended medical school in Rochester, NY, our second-year course on interviewing patients was run by Dr. George Engel, a teacher certified in both medicine and psychiatry. During the course, for 10 consecutive weeks, he conducted interviews before the class. (We were separated from him and the patient by a one-way mirror. We were in a darkened classroom; he and the patient were in a small, adjacent, brightly lighted room, their voices piped in to us.) Each week, for an hour, he interviewed a different patient. He'd instructed his chief resident to choose 10 patients for him, and he knew nothing about them in advance, except that each was a diabetic.

Over that 10-week period, we became amazed at the various things Dr. Engel brought out in each patient's history, showing us how various facets of a patient's life were affected by his or her illness. Indeed, the "take-home" message was that, more often than not, illness affects almost every aspect of a patient's life. Engel convincingly showed us how the body, the mind, and the spirit reacted and interacted in response to illness or injury. The obvious inference was that we would take better care of our patients if we heeded, respected—and *looked for*—that interplay. From that experience in medical school, I became convinced that we need to pay attention to the body, mind, and spirit to have the best chance of helping our patients.

After medical school, I went on to become a general surgeon. In the course of my training I came to realize that not all surgeons are created equal. Here are two illustrative examples. When I was a senior resident, I had joint responsibility for the head and neck service of the Veterans Affairs (VA) Hospital in Portland with an excellent otolaryngology resident named Maurice. As was and is typical of VA patients, many exhibited the ravages of life-long smoking and drinking. In particular, on our service we had many patients who had cancer of the larynx, a sad disease that we often treated with laryngectomy. As a result of the surgery, patients lost their voice, an additional trauma besides the big operation. Pre-operative counseling in these men was crucial, and Maurice and I were dismayed that our own busy schedules didn't allow us to spend much time talking to these patients preoperatively, for we spent long hours in the operating room and had many patients on the service to round on daily.

To help inform and counsel these patients who were facing loss of their larynx, we formed a team approach involving

a nurse, a chaplain, a social worker, and the two of us. One member of this team would spend at least an hour talking with each patient before surgery. It seemed to work, for we noted the patients did better, seemed to have fewer complications, and were better motivated to learn esophageal speech than if we'd not spent the extra time.

It happened that every Friday, the chief—the professor in charge of all the surgical services in that VA hospital—made teaching rounds with all of the residents, walking the wards and seeing every patient. Some were seen very briefly, even just from the door of the room, while others might be examined at the bedside by the chief. The whole process was edifying and educational and took about 3 hours. Besides being a great learning experience for us, it was a way that the chief kept tabs on the service.

On this particular Friday, Maurice and I had been using our team approach for about a month, and we decided it was time to tell the chief about it. So I explained what we'd done and the good results we thought we were getting, concluding with the statement that we were glad we'd instituted the team program, for much as we would like to, we were just too busy to spend an hour chatting with each patient. The chief, a general surgeon who was nationally known for his innovations in vascular surgery, looked at me, cocked his head, and said, "*I can't imagine spending an hour talking to a patient!*" Yet we regarded him as a superb surgeon, and he was a man who would spend 3 hours with us operating on a sleeping patient who had an abdominal aortic aneurysm!

Contrast that experience with this vignette about a medical student on the service of Harvey Cushing, the great neurosurgeon. The student was an extern assigned to work up one of Cushing's brain tumor patients, a middle-aged man who was to have a craniotomy in the morning. As the student, carrying his black bag and notebook, rounded the corner to come into the patient's room, he saw a man in a dark suit sitting in a chair at the bedside, his back to the student, reading the Bible to the patient. Assuming it was a clergyman, the student said, "I'm sorry, Father. I will come back a little later." The man turned around and the student recognized Harvey Cushing.

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Perhaps the patient had asked Cushing to read to him, or perhaps Cushing had realized that was what this patient needed at this particular time. Not all of us are as sensitive as Cushing, and probably most of us are not as familiar with the Scriptures as he was. But the story gives a different slant on the surgeon at the bedside than did my previous story. Different patients have different needs, and we need to call upon a variety of others to help if we ourselves cannot meet those needs. Of course, we do this all the time with consultants.

I had a broad but restricted practice; I didn't do orthopedics or cardiac surgery, for example. In order to excel and to be able to adequately keep up, I restricted the scope of my practice. The logical corollary of that decision is that I could not cover the whole field of surgery, let alone the vast expanse of medicine. So, in desiring to take the best care of my patients, I called upon others and sought consultation outside my own area of expertise. An experience early on in my practice taught me an important lesson. It occurred not long after I completed my surgical residency. I'd stayed on the faculty and was directing the emergency department at the University of Oregon Hospital in Portland at the time.

One afternoon, one of the interns presented the case of a boy named Taddio, a high school cross-country runner with a sore knee. His mother was an immigrant from Poland, although Taddio was born here. He did not recall a specific injury, and the intern, whose exam was negative, asked if he should do an x-ray. I said yes, because on rare occasions in a young man you may discover a bone tumor. So it happened. The x-ray showed that Taddio had a cancer, a sarcoma of the femur, and we referred him to the orthopedic surgeon for further care.

Fast forward about 2 years. I'd taken a job across town as the director of the emergency department in a large Catholic hospital. At the time I was an elder in a suburban Presbyterian church, and one day I got a call from a fellow elder who was a teacher and coach at Lake Oswego High School. He said one of his students was in the hospital, and could I please visit him. His name, he said, was Taddio; he was estranged from his mother and was dying from metastatic cancer. I recognized the uncommon name.

It turned out that back when I'd first met him, the orthopedists recommended that Taddio have an amputation, but he refused, despite his mother's urging. They had tried chemotherapy to no avail, and now the cancer had spread to his lungs. He was dying and was an angry young man. I visited him alone at first, then several more times with the hospital chaplain and with his mother. I could do nothing about the tumor, but together we were able to effect a reconciliation, a healing of the broken relationship with his mother, before he died. As a young, scientifically trained surgeon, I learned a great lesson: there were other forms of healing besides surgery or medication that we were called to be part of, and there were others, specially trained, who could help.

The well-known medical ethicist Albert Jonsen has described what he terms the central ethical paradox of the practice of medicine, which is *the tension between self-interest and altruism*. In the context of these two stories, it amounts to asking ourselves, "*Am I going to put my own interests ahead of those of*

my patient?" It's a question that underlies much of our behavior in medicine and surgery.

In medical education circles today, there's a lot of interest in *professionalism*, which as an interested observer I see as an attempt to improve the standing and image of doctors by drawing them back to the great virtues of the profession, many of which have been lost or blunted as modern medicine has been transformed by technology and managed care. (Medicine, in fairness, has suffered from many of the same woes that American society has suffered from over the past 50 years.) Professionalism has been touted as one of the six major competencies that graduating residents should possess, and it includes caring and altruism. Perhaps in days gone by, when we did not have such a wide range of wonder drugs and dazzling techniques, much of what doctors dispensed was care and concern—and doubtless there was less material to master in the medical school curriculum and more time to spend with an individual patient. But I'd submit the fundamental approach has not changed: the secret of the care of patients is truly *caring* for them, that is, being competent and concerned, able to put their needs ahead of our own.

Since none of us can adequately cover the entire medical or surgical waterfront, and patients' needs vary widely, it behooves us as competent doctors to be sensitive to their needs—body, mind, and spirit—and to be familiar with a broad range of colleagues with whom to consult to give patients the best care. In that regard, my own religious persuasion is much less relevant than the fact that I am sensitive to some of the issues.

I once shared my concern with a hospital chaplain in Arizona that relations between physicians and pastors need attention. He agreed and said that the problem was universal, in his experience. He'd been a full-time chaplain for several years and said he felt that most of the time he was called in far too late to be of great help and often felt "like the pooper-scooper at the end of the parade." By that he meant many medical professionals saw his role as picking up the pieces, being relevant only after a patient died, whereas he believed he could assist (and was trained) in a much greater variety of situations: before or after surgery or with a waiting family; when a patient has a serious, painful, severely disabling, or incurable illness or faces an alteration in lifestyle; when a patient seems to need moral guidance or value clarification; when a patient has few or no visitors or is depressed.

Another pastor shared with me an experience he had during a clinical pastoral education training session at a medical center in the Midwest. A head nurse pulled him over one day because an obstetrician on the staff had written an order on the chart that henceforth the chaplain was to see *none* of his patients. She said that this doctor had come to the ward and saw one of the chaplains seated at the bedside of one of his patients; the woman was crying and obviously distraught. He was angry that the chaplain had obviously gotten her emotionally riled up. But what the head nurse knew (and the attending doctor did not appreciate) was the patient was grieving over the loss of her stillborn baby, and the chaplain was helping her through the process. My pastor friend, who knew the doctor pretty well,

said he did something then (this was about 20 years ago) that he probably wouldn't have the guts to do today: namely, he went up to surgery, put on a set of scrubs and cap and mask, and went in to the operating room where the doctor was doing a hysterectomy. He told the surgeon that he'd gone off half-cocked and hoped he'd reconsider the order he'd written. The doctor was understanding (and humble) enough to benefit from the conversation, and he did indeed rescind the order.

In closing, it might be worth suggesting a way that physicians can inquire about the spiritual concerns of their patients. In history taking, the simple mnemonic SPIRIT (1) can bring to mind six areas of inquiry:

S – Do you have a **S**piritual belief system?

P – Do you have any **P**ersonal spiritual **P**ractices?

I – **I**ntegration: Are you part of a spiritual community?

R – Do you have any **R**eligious restrictions?

I – Does your faith have **I**mplications for medical care?

T – (Near the end of life) What about **T**erminal events planning?

Approached with tact and sensitivity, most patients do not mind such inquiries, and the information obtained is often valuable in helping care for patients and attend to their needs and desires. I've also found it worthwhile, when a patient is a

member of a religious community, to ask if they would like to have their pastor or rabbi made aware that they were in the hospital. If so, the nurse could contact the appropriate clergy. Before privacy became a big issue, hospitals used to keep lists of patients' religious preferences that could be consulted by visiting clergy—but by law, that happens no more. Yet I have found that clergy welcome knowing when their parishioners are hospitalized.

When I was a first-year medical student, I went to India on a program called the *Experiment in International Living*, in which I lived with five Indian families. As you may know, Indians greet one another with hands together—hands held as depicted in Albrecht Durer's famous etching of the Hands—as they bow slightly and say "Namaste." I was impressed at that time, and have continually been impressed since, with what an appropriate symbol that remains of the totality of life. You can regard the two hands as symbolic of faith and reason. Both are needed, in balance, in our lives. Carrying that analogy a bit further, it could apply to balanced care of our patients: we need medicine *and* religion, physicians *and* pastors, to adequately care for the whole person.

1. Maugans TA. The SPIRITual history. *Arch Fam Med* 1996;5(1):11–16.